

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |   |  |  |                            |
|--|---|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15E064</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br>B. WING _____                |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/06/2012</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKSIDE HAVEN</b> |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>505 N GAVIN ST<br/>MUNCIE, IN 47303</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| K 000  | <p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/06/12</p> <p>Facility Number: 000311<br/>Provider Number: 15E064<br/>AIM Number: 100285520</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brookside Haven was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in resident sleeping rooms. The facility has a capacity of 42 and had a census of 40 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety</p> |  |  | K 000   |  |  |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |   |  |  |                            |
|--|--|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15E064</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br>B. WING _____                      |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/06/2012</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKSIDE HAVEN</b> |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>505 N GAVIN ST</b><br><b>MUNCIE, IN 47303</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| K 000  | Continued From page 1<br>Code Specialist-Medical Surveyor on 12/07/12.   |  |  | K 000   |  |  |                            |